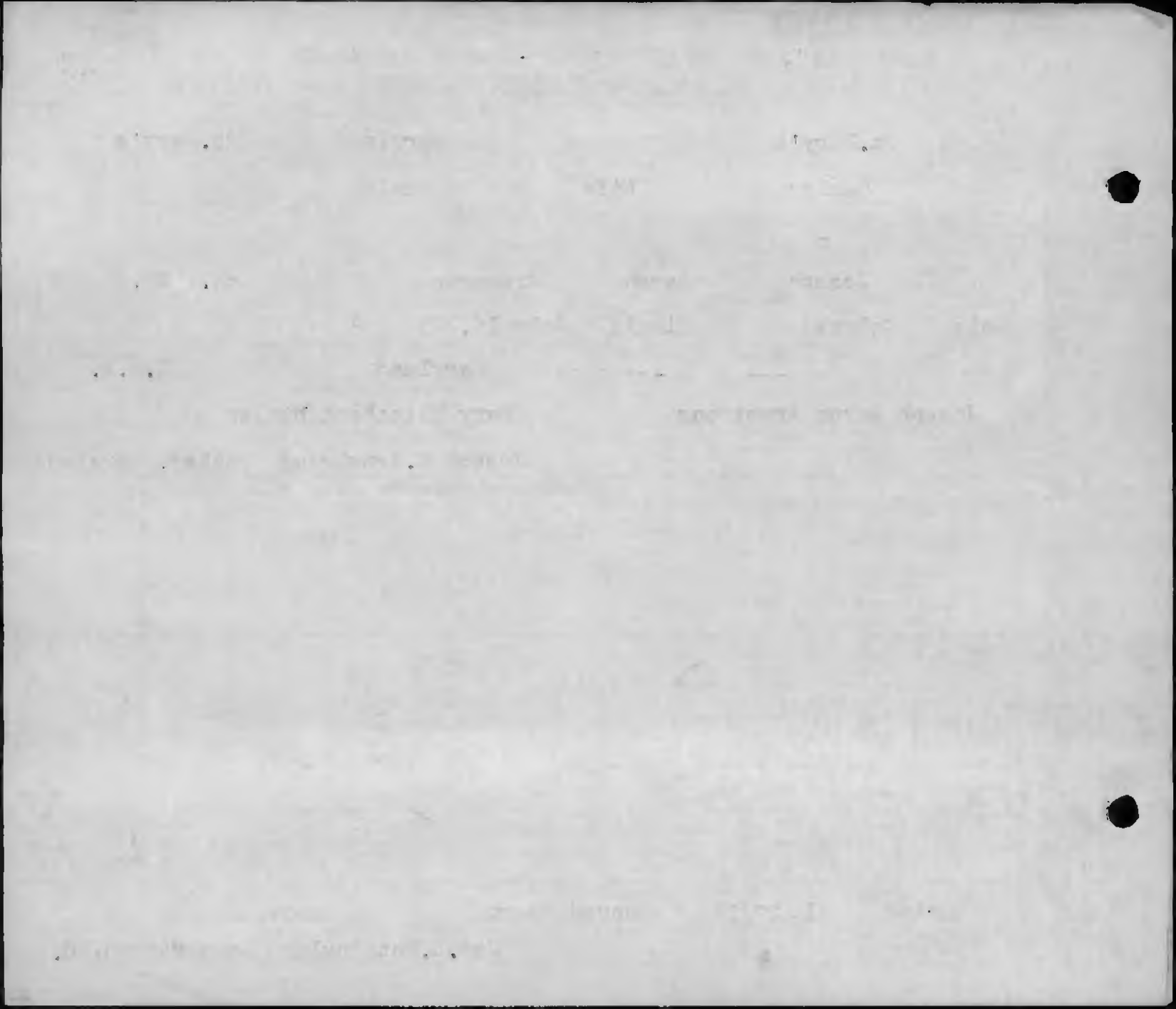


PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

10093		10093	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY St. Mary's	MARYLAND	STATE Maryland	COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR	
TOWN Oakley	Life	TOWN Oakley	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Joseph	(Middle) Aaron	(Last) Armstrong	(Month) Oct. (Day) 25 (Year) 19 55
(Type or Print)			
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: July 16, 1952
			9. AGE last birthday: 3 Yrs. (If under 1 year) (If under 24 hrs.)
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland
			12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Joseph Aaron Armstrong		14. MOTHER'S MAIDEN NAME: Mary Elizabeth Butler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: Joseph A. Armstrong Oakley, Maryland	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
204.1 Immediate cause (a) Myeloid leukemia DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE Paul F. Green		DATE SIGNED	
		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Buried		DATE THEREOF 10/27/55	NAME OF CEMETERY OR CREMATORY Sacred Heart
		LOCATION (City, town, or county) (State) Bushwood	
DATE REC'D. BY LOCAL REG. 10/25/55		24. FUNERAL DIRECTOR Jos. C. Mattingley Leonardtown, Md.	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10094

10100

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Leonardtwn		15 day's		TOWN Rural Great Mills			
HOSPITAL OR INSTITUTION OR STREET ADDRESS St. Mary's Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Walter Spencer Bulla				4. DATE OF DEATH (Month) (Day) (Year) Oct. 25 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 26, 1883	9. AGE last birthday #71 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad		10b. KIND OF BUSINESS OR INDUSTRY Clerk		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Morton Bulla				14. MOTHER'S MAIDEN NAME Elizabeth Spencer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or both) NO		16. SOCIAL SECURITY NO. 704-16-8427		17. INFORMANT & ADDRESS Mary L. Bulla Great Mills, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage						15 days	
ANTECEDENT CAUSE(S) DUE TO (B) General arteriosclerosis						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct. 10, 1955 , to Oct. 25, 1955 , that I last saw the deceased alive on Oct. 25, 1955 , and that death occurred at 11:10 P.M. , from the causes and on the date stated above.							
SIGNATURE M. B. Bulla				ADDRESS (Street, city, town, state) Great Mills, Md.		DATE SIGNED 10/26/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/28/55		NAME OF CEMETERY OR CREMATORY Chestnut Hill		LOCATION (City, town, or county) (State) Salisbury, North Carolina	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE M. B. Bulla		25. FUNERAL DIRECTOR'S SIGNATURE Jos. C. Matthews		ADDRESS Leonardtwn, Md.	
DATE Oct 24/55							

INSTRUCTIONS

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 1 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10095

CERTIFICATE OF DEATH

10101

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>St. Marys</u>		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Compton</u>				TOWN <u>Compton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>St. Clements Shores</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>Rosevear</u> (Last) <u>Chaplin</u>				(Month) <u>10</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	10. IF UNDER 1 YEAR	
<u>male</u>	<u>white</u>	<u>married</u>	<u>November 17, 1902</u>		<u>52</u> yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Supervisor</u>		<u>Civil Service</u>		<u>Pennsylvania</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Frank J. Chaplin</u>				<u>Rhoda Rosevear</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Mollie P. Chaplin - Compton, Maryland.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>200.1 Cachexia, malnutrition</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Lymphosarcoma</u>						<u>18 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>10/17/55</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		21h. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 17, 1955</u> to <u>Oct 17, 1955</u>, that I last saw the deceased alive on <u>Oct 17, 1955</u>, and that death occurred at <u>10:50 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>J Roy Guyther</u>		<u>Mechanicville</u>		<u>10/18/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/19/55</u>		<u>Cedar Hill Cemetery</u>		<u>Washington, D.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Alfred D. Houser</u>		<u>P.B. Robinson - Leonardtown, Md.</u>			
DATE							
<u>10-19-55</u>		<u>Davis</u>					

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

BUREAU V. 1

OCT 20 1955

RECEIVED

INSTRUCTIONS

1. This certificate is to be filled out by the attending physician or the coroner. It is to be signed by the physician or coroner and filed with the local health department. A copy of this certificate is to be sent to the State Department of Health, Boston, Massachusetts.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10096

CERTIFICATE OF DEATH

10102

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN Leonardtwn		1 day		OR TOWN Rural Charlotte Hall		X	
HOSPITAL OR STREET ADDRESS St. Mary's Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) George Francis Dade				4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1955			
5. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single		8. DATE OF BIRTH April 30, 1952	
9. AGE last birthday 3 yrs.		IF UNDER 1 YEAR 5 Months 28 Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Corinilous Dade				14. MOTHER'S MAIDEN NAME Mary E. Barns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Jos. E. Dade Charlotte Hall, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 5 days			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) Bilateral Bronchitis (Pneumonia)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/27</u> , 19 <u>55</u> , to <u>10/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/27</u> , 19 <u>55</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
SIGNATURE <i>Whit D. B...</i> M.D.				ADDRESS (Street, city, town, state) <i>Leonardtwn Md</i>		DATE SIGNED <i>10/27/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/28/55		NAME OF CEMETERY OR CREMATORY Ebenezener		LOCATION (City, town, or county) (State) Charlotte Hall, Md.	
24. REC'D BY REGISTRAR 10-28-55		REGISTRAR'S SIGNATURE <i>Alvin L. Hauser</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>James C. Mattingly</i> ADDRESS Leonardtwn, Md.			

ENCLOSURE

RECEIVED
FEB 10 1934
U. S. DEPARTMENT OF JUSTICE
BUREAU OF INVESTIGATION
WASHINGTON, D. C.

CERTIFICATE OF DEATH

10006

MASSACHUSETTS DEPARTMENT OF HEALTH-CAMBRIDGE, 12

Name of deceased		Joseph Benjamin Bado	
Sex		Male	
Age		38	
Date of birth		April 30, 1895	
Place of birth		Barnstable, Mass.	
Cause of death		Typhoid fever	
Date of death		April 30, 1934	
Place of death		St. Mary's Hospital, Boston, Mass.	
Occupation		None	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Signature of informant		[Signature]	

BUREAU V. 2

NOV 1 1934

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10103

10097

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		STATE Maryland		COUNTY St. Marys			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN Wynn		6 yrs.		OR TOWN Wynn			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Estelle (Middle) Cole (Last) Dominy				(Month) 10 (Day) 21 (Year) 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
female	white	married	Aug. 25, 1890	65 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		Domestic		Washington, D.C.		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles D. Cole				Augusta M. Geisler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		345-07-7142 B		Carl G. Dominy - Wynn, Maryland.			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A)						1 month	
ANCECEDENT CAUSE(S) DUE TO (B)						20 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION						20. AUTOPSY?	
none						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
none		none		none			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
none		none		none			
22. I hereby certify that I attended the deceased from 2/10/54 to 10/21/55, that I last saw the deceased alive on 10/20/55, and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
John S. Lewis M.D.				10/21/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10/23/55		Trinity Cemetery		St. Marys City, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE 10-21-55		Local		Leonardtown, Md.			

50103

RECEIVED STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

100097

NAME OF DECEASED	DATE OF DEATH
SEX	AGE
PLACE OF BIRTH	DATE OF BIRTH
CITY	STATE
COUNTRY	

CAUSE OF DEATH	IMMEDIATE	INTERMEDIATE	FINAL
1	2	3	4

1	2	3	4
5	6	7	8

1	2	3	4
5	6	7	8
9	10	11	12

BUREAU V. 2

OCT 24 1955

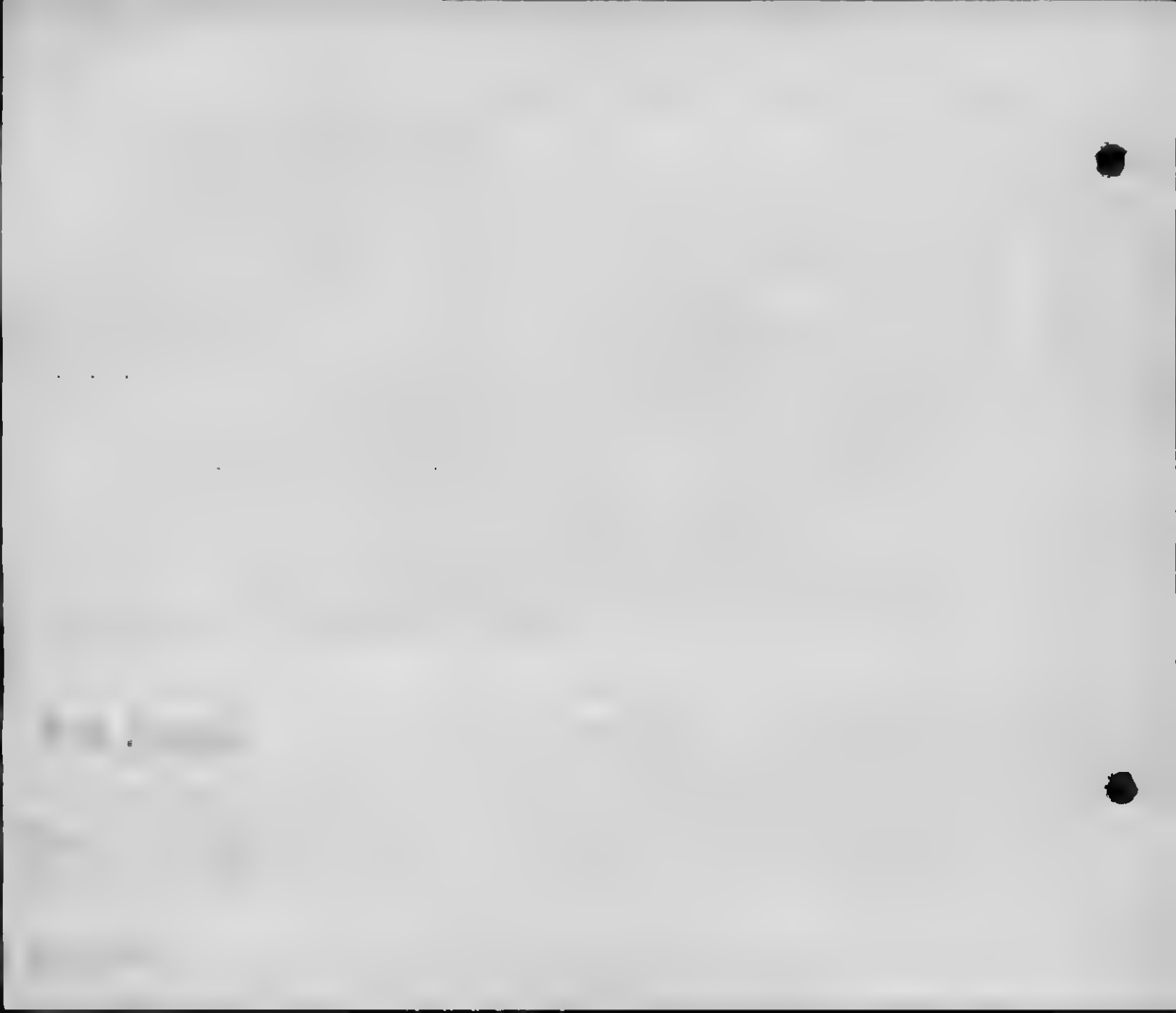
RECEIVED

NON-REPORT

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10098				10104			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 287							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY Saint Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Laurel Grove				TOWN Morganza			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural				STREET ADDRESS (If rural, give location) Rural			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
John Columbus HOLT				October 14, 1955			
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 2 / 12 / 12	
9. AGE last birthday: 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Farming		10b. KIND OF BUSINESS OR INDUSTRY: Farm		11. BIRTHPLACE (State or foreign country): Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME: Philip Holt			
14. MOTHER'S MAIDEN NAME: Sarah Stewart				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No			
16. SOCIAL SECURITY No.: _____				17. INFORMANT & ADDRESS: Vilot M. Coates * 309 U St. N.W., Wash. 1, DC			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
824X Immediate cause (a) Intercranial hemorrhage						Immediate	
Antecedent cause(s) (b) Fractured skull						Immediate	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19a. DATE OF OPERATION: none				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OF CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, street, office, etc.) OF INJURY: Laurel Grove, St. Mary's, Md.		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 10 14 55 P.M.		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? Fell off truck & under rear wheel.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE: [Signature]				M. D. [Signature]			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF: 10/17/55		NAME OF CEMETERY OR CREMATORY: St. Joseph's Cemetery		LOCATION (City, town, or county) (State): Morganza, Maryland	
DATE REC'D BY LOCAL REG: 10 / 17 / 55		REGISTRAR'S SIGNATURE: [Signature]		24. FUNERAL DIRECTOR: P. B. Robinson		ADDRESS: Leonardtown, Maryland.	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

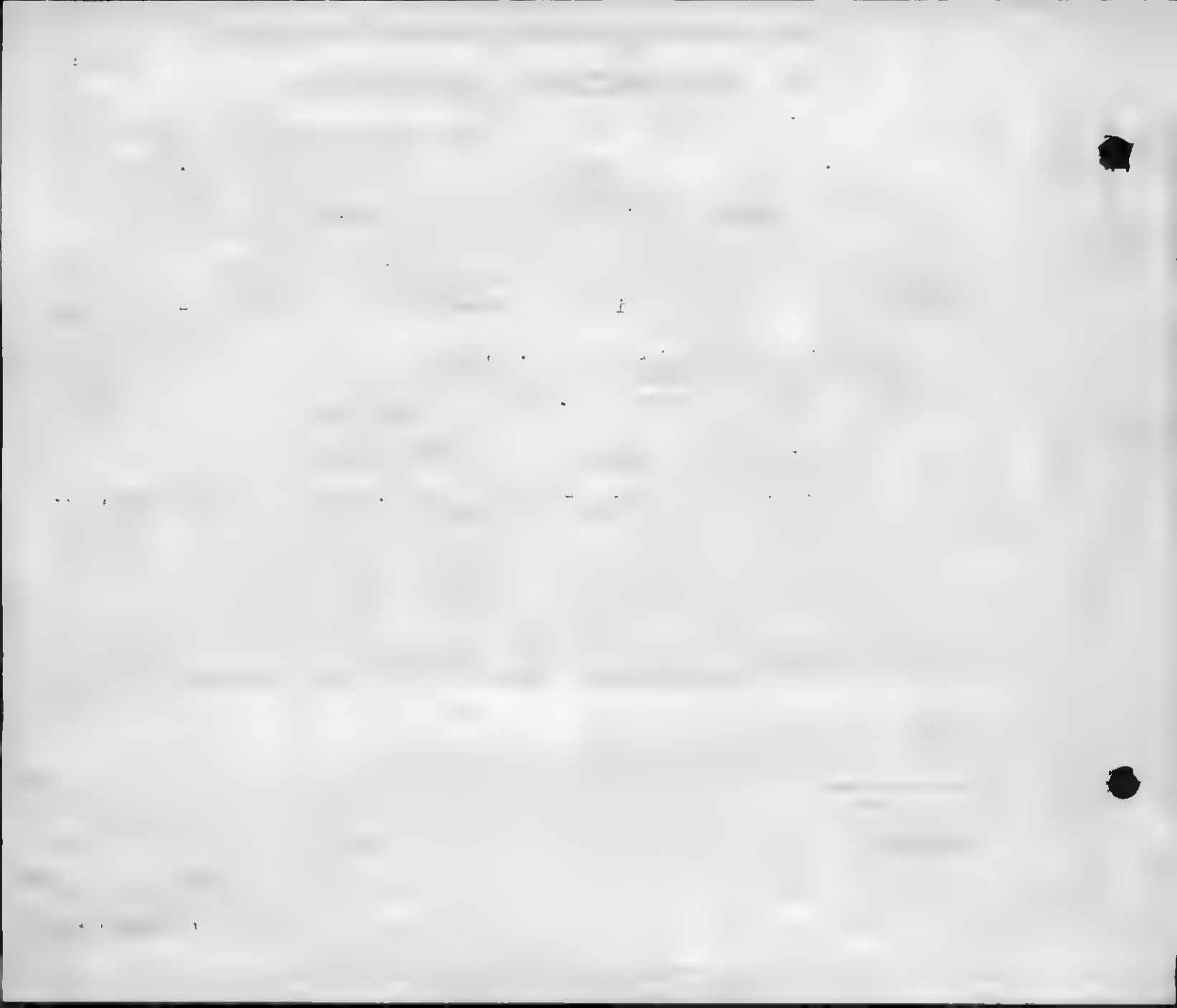
10099

CERTIFICATE OF DEATH

10105

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		STATE Maryland		COUNTY St. Marys			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Hermansville				TOWN Hermansville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				Rural			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) Thomas (Middle) Frederick (Last) Hopewell				10 - 25 - 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	colored	married	Feb. 12, 1888	67 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
School janitor		State of Md.		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Hopewell				Maria Chase			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		218- 07-211		Agnes P. Hopewell- Hermansville, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) Chronic Myocarditis						INTERVAL BETWEEN ONSET AND DEATH 3.4 years	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis						10 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 15, 1955 to Oct 25, 1955 , that I last saw the deceased alive on Oct 15, 1955 , and that death occurred at 8 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. H. P. Patrich		M.D. Lexington Park Md.		DATE SIGNED 10-27-55			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10/28/55		Holy Face Cemetery		Great Mills, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
10/27/55		R. B. L. L. L.		C. F. Robinson - Leonardtown Md.			



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10:00

CERTIFICATE OF DEATH

10106

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Rural Medley's Neck		6 yrs.		TOWN Rural Medley's Neck		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
William Ernest Knott				10/19/55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
Male	White	Widowed	11/3/1888	67 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer		Farm		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name of unit) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		No		213-22-1335 William E. Knott Medley's Neck, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Coronary occlusion						1 hour	
ANTECEDENT CAUSE(S) DUE TO (B) Coronary atherosclerosis						8 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 17, 1955 to Oct 17, 1955 , that I last saw the deceased alive on Oct 17, 1955 , and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
P. J. B. [Signature]		G. M. [Signature]		10 F. [Signature]		Oct 20/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10/22/55		St. John's		Hollywood, Md.	
24. REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct 20/55		[Signature]		Jos. C. Mattingley		Leonardtwn, Md.	

211 087800
OCT 1960

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 12 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

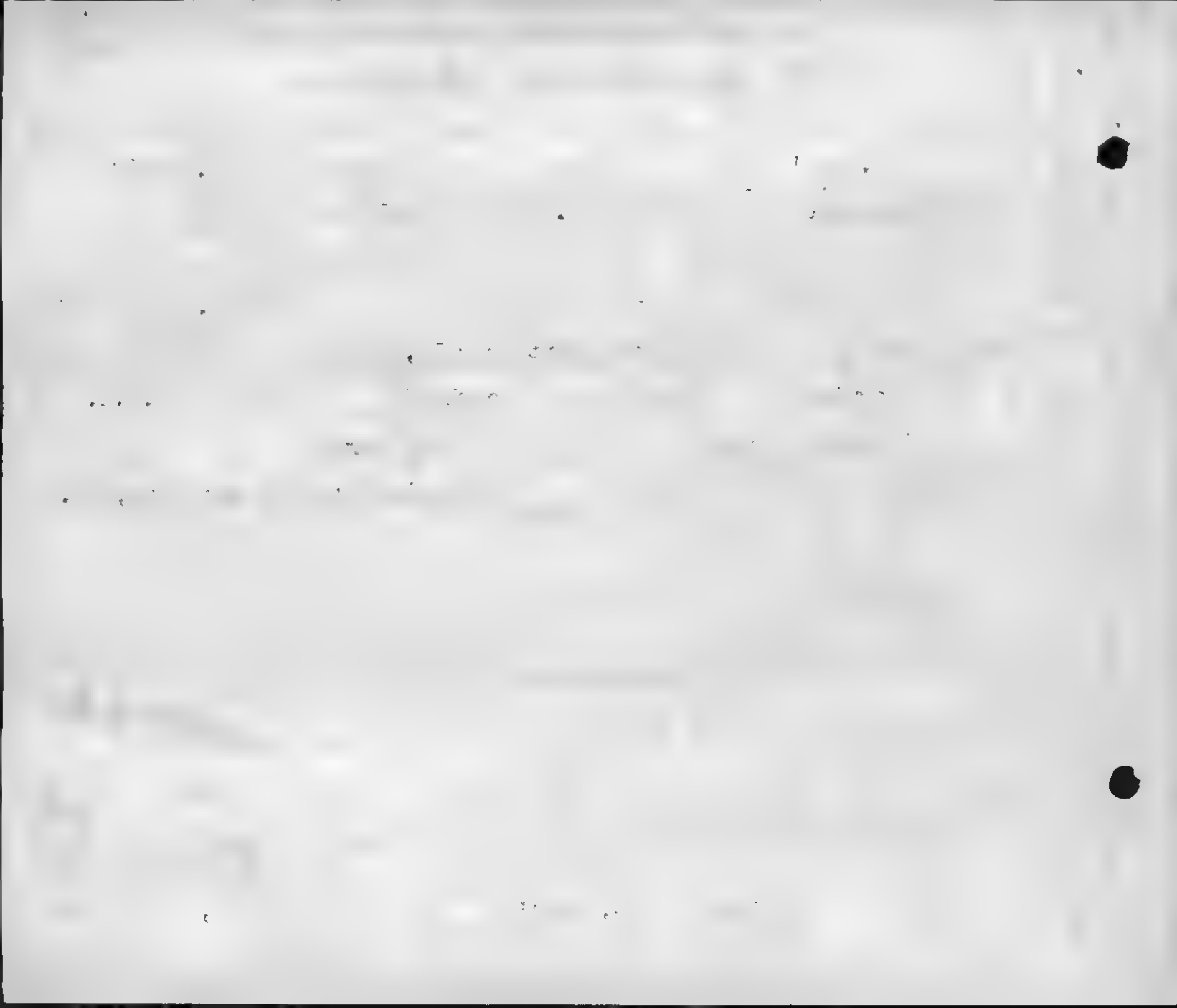
10108

10101

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Hollywood		40 yrs.		TOWN Hollywood			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) George (Middle) Franklin (Last) McKay				(Month) Oct. (Day) 21 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widowed	September 17, 1872	83 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farming		Farm		Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Mitchell McKay				Mary Cox			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
NO		NONE		Manning McKay Leonardtown, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.1 Coronary occlusion				is known			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis				10 years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Cholecystitis				6 months			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 21, 1955 to Oct 21, 1955 , that I last saw the deceased alive on Oct 21, 1955 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE M. B. [Signature]				ADDRESS (Street, city, town, state) West Mills Rd		DATE SIGNED 10/22/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		10/24/55		St. John's		Hollywood, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Oct 22/55		[Signature]		Joe C. Mattingley		Leonardtown, Md.	



10102

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chaptico</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chaptico</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Barbara</u> (Middle) <u>Williamina</u> (Last) <u>Miles</u>				4. DATE OF DEATH: (Month) <u>Oct</u> (Day) <u>4</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>Negro</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Aug. 4 1955</u>	
9. AGE last birthday: <u>2</u> yrs. <u>2</u> Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min.		10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>George Fredrick Miles</u>			
14. MOTHER'S MAIDEN NAME: <u>Grace M. Nelson</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY No.: <u>—</u>				17. INFORMANT & ADDRESS: <u>George F. Miles Chaptico, Md.</u>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
571.0 Immediate cause (a) <u>Diarrhea</u>				1 Week	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO					
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY Y	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct. 3, 1955</u> , to <u>Oct. 4, 1955</u> , that I last saw the deceased alive on <u>Oct. 3, 1955</u> , and that death occurred at <u>9:05 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>J. Beam</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Great Mills Md.</u> DATE SIGNED <u>10/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>10-6-1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-4-1955</u>		REGISTRAR'S SIGNATURE <u>J. Beam</u>		LOCATION (City, town, or county) (State) <u>Morgansville Md.</u>	
24. FUNERAL DIRECTOR		ADDRESS			
<u>Jos. E. Mathias</u>		<u>By Leonard</u>		<u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Б. А. ОУДОВ

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1917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10103

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

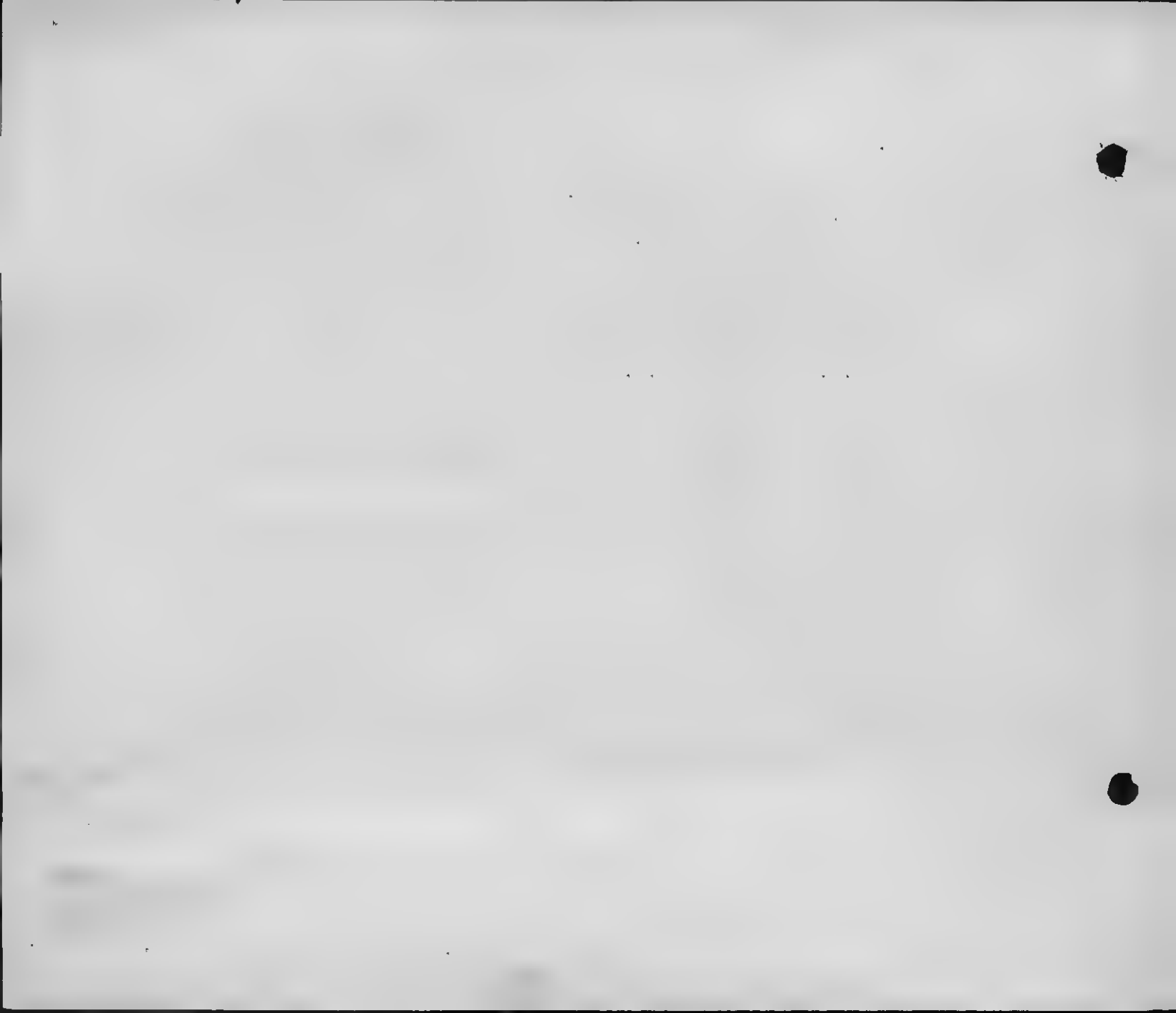
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10109

Reg. Dist.

No. 231

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>St. Marys</u>		MARYLAND		STATE <u>Colorado</u>		COUNTY <u>unknown</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Lexington Park</u>		LENGTH OF STAY (in this place) <u>3 mo.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Fort Collins</u> <u>44 X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Naval Hospital</u> <u>Patuxent River, Md.</u>				STREET ADDRESS (If rural, give location) <u>1601 North College Ave.</u>			
3. NAME OF DECEASED: (First) <u>Loren</u> (Middle) <u>Dale</u> (Last) <u>Moody</u>				4. DATE OF DEATH (Month) <u>10</u> (Day) <u>24</u> (Year) <u>19 55</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>11 - 1 - 1924</u>	9. AGE last birthday: <u>30</u> yrs.	IF UNDER 1 YEAR (Month) (Day) (Year) IF UNDER 24 HRS. (Month) (Days) (Hours) (Min.)		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>U.S. Navy</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U.S. Navy</u>		11. BIRTHPLACE (State or foreign country): <u>Wyoming</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>E.N. Moody</u>				14. MOTHER'S MAIDEN NAME: <u>Amy Willinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>12/12/42 to 10/24/55</u>		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Official Navy Records</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>976X</u> Immediate cause (a) <u>Penehring bullet wound of brain</u> DUE TO							<u>immediate</u>
Antecedent cause(s) (b) <u>DUE TO</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION: <u>none</u>				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Lexington Park, St. Marys, Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10 24 11 AM.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>self inflicted with own revolver</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
SIGNATURE <u>[Signature]</u>		M. D. <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>10/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Transportation</u>		DATE THEREOF <u>10/26/55</u>		NAME OF CEMETERY OR CREMATORY <u>Local</u>		LOCATION (City, town, or county) (State) <u>Jackson, Wyoming</u>	
DATE REC'D BY LOCAL REG. <u>10-27-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>P.B. Robinson - Leonardtown, Maryland.</u>		ADDRESS	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10104 Items 2,5, Film 187 10-10-55 et
CERTIFICATE OF DEATH

10110

Reg. Dist. No. 282

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St. Mary's</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Leonardtown</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Helen</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St Mary's Hospital</u>		STREET ADDRESS (If rural give location) <u>-----</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)		
<u>Infant Morgan</u>	<u>Oct 2</u> <u>1955</u>		
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Oct 4, 1955</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>1</u> yrs. <u>2</u> Months <u>2</u> Days <u>0</u> Hours <u>0</u> Min.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John N. Morgan</u>		14. MOTHER'S MAIDEN NAME: <u>Hazel Samton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-----</u>	
17. INFORMANT & ADDRESS: <u>John N Morgan Helen, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Respiratory arrest</u>			<u>8 hours.</u>
ANTECEDENT CAUSE (B) <u>Immaturity, Prematurity</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 1</u> , 1955, to <u>Oct 2</u> , 1955, that I last saw the deceased alive on <u>Oct 1</u> , 1955, and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Joseph E. Gill</u>		DATE SIGNED <u>10/2/55</u>	
M. D. <u>Leonardtown, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10/3/55</u>	NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	LOCATION (City, town, or county) (State) <u>Morgans, Md</u>
DATE REC'D BY LOCAL REGISTRAR <u>10/3/55</u>	REGISTRAR'S SIGNATURE <u>Glenn D. Wolney</u>	24. FUNERAL DIRECTOR <u>W. S. Mattingly</u> ADDRESS <u>Leonardtown, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOOKED BY

100-100000
100-100000
100-100000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10105

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 282

10111

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY St. Mary's		MARYLAND		STATE Maryland		COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN Rural Mechanicsville		18 yrs.		TOWN Rural Mechanicsville		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
Gertrude		Agnes		Owens		Oct. 17, 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
Female		White		Married		January 27, 1894	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: (61) yrs.		11. BIRTHPLACE (State or foreign country):	
Housewife		Home		Maryland		U.S.A.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William Wathen				Sarah Morgan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
(If Yes, give war or dates of service)				Moses Owens Mechanicsville, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) ... Coronary atherosclerosis DUE TO Antecedent cause(s) (b) ... Arterio-sclerosis Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						10 days	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: none							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
none				none			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
none		none		none		none	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
none		none		none			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER		DATE SIGNED	
John A. Owens		M. D.		DEPUTY MEDICAL EXAMINER		10/18/55	
23. BURIAL, CREMATION, (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		10/19/55		St. Joseph's		Morganza, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
10-18-55		John A. Owens		Jos. C. Mattingley		Leonardtown, Md.	

U. S. AIR FORCE

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10-06

CERTIFICATE OF DEATH

Reg. Dist. No. 281

10112

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>St Mary's</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Patuxent River, Md.</u> LENGTH OF STAY (In this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Station Hospital, U.S. Naval Air Station, Patuxent River, Md.</u>		STATE <u>Delaware</u> COUNTY <u>St. Mary's</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lexington Park Claymont</u> STREET ADDRESS <u>8307 Tower Road</u> <u>-295 Ghinlee Drive (see birth cert.)</u>	
3. NAME OF DECEASED.		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Cindy Lou Reese</u>		OF DEATH: <u>Oct 22 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:
<u>Female</u>	<u>Caucasian</u>	<u>Single</u>	<u>10-21-55</u>
9. AGE last birthday:		10. BIRTHPLACE (State or foreign country):	
<u>10-21-55</u>		<u>Maryland</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>John R. Reese</u>		<u>Margaret Ann Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<u>(If Yes, give war or dates of service)</u>			
17. INFORMANT & ADDRESS:			
<u>John R. Reese Address: same as # 2</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>776X IMMEDIATE CAUSE</u>		<u>1 hr. 35 m.</u>	
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Prematurity, Neonatal death</u>			
(B) <u></u>			
(C) <u></u>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10-21</u> , 1955, to <u>10-22</u> , 1955, that I last saw the deceased alive on <u>10-22</u> , 1955, and that death occurred at <u>1230A</u> M. from the causes and on the date stated above.			
SIGNATURE <u>LTJG R.D. IRONS MC USNR</u>		DATE SIGNED <u>10-24-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Removal</u>		<u>Claymont, Delaware</u>	
DATE REC'D BY LOCAL REGISTRAR <u>10-24-55</u>		REGISTRAR'S SIGNATURE <u>PJ Beane</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>John R. Reese</u>		<u>Patuxent River, Md.</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10107

CERTIFICATE OF DEATH

10113

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		MARYLAND		STATE District of Columbia			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Leonardtwn		14 hrs.		TOWN Washington		47X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
78 St. Marys Hospital				1421 -19th Street S.E.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
William Leonard Stevens				10/31/1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	married	Feb. 19, 1900	55 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Auto Mechanic		Temple Motors		Virginia		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Temple Stevens				Elizabeth Hughes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		577-16-0137		1421-19th St. S.E. Cecilia M. Stevens- Washington, D.C.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
540.0 IMMEDIATE CAUSE (A)				Intestinal hemorrhage			
ANTECEDENT CAUSE(S) DUE TO				Bleeding Meckel's diverticulum			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				or stomach ulcer			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				14 hrs			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10:30 , 19 55 , to 10:31 , 19 55 , that I last saw the deceased alive on 10:30 , 19 55 , and that death occurred at 6 A .M., from the causes and on the date stated above.							
SIGNATURE Frank Mink				DATE SIGNED 10.31.55			
M.D. Leonard Mink				ADDRESS (Street, city, town, state) 1661 Good Hope Rd. S.E. Wash. D.C.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11/2/55		Fort Lincoln Cemetery		Bladensburg, Maryland.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 10/31/55		Alan D. Houser		Lincoln B. Davis			

CERTIFICATE OF DEATH

10117

Form No. 10-1-1961

Division of Health

Washington

DATE OF DEATH

10-1-1961

10-1-1961

10-1-1961

10-1-1961

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10108

CERTIFICATE OF DEATH

10114

Reg. Dist. No. 281

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY St. Marys		MARYLAND		STATE Maryland		COUNTY St. Marys	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Callaway		27 yrs		TOWN Callyway		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				Rural			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) James (Middle) -- (Last) Thompson				(Month) 10 (Day) 29 (Year) 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	colored	married	May 7, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
farming		farm owner		Maryland		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Thompson				Sophia Briscoe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
no				-----		Nellie B. Thompson, Callaway, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) Coronary thrombosis						INTERVAL BETWEEN ONSET AND DEATH 2 months	
ANTECEDENT CAUSE(S) DUE TO (B) General atherosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						6 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
0							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White el work Not while el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1, 1955 to Oct 29, 1955 , that I last saw the deceased alive on Oct 25 1955 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) [Signature]			
				DATE SIGNED 10/30/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		11/2/55		St. Georges Cemetery		Valley Lee, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Oct 30/55		[Signature]		[Signature]		Leonardtwn, Md.	

10108 CERTIFICATE OF DEATH

10114

10114

Name of Deceased J. M. Smith		Date of Birth Jan. 1, 1900	
Sex Male		Race White	
Usual Residence 123 Main St., Baltimore, Md.		Date of Death Dec. 15, 1950	
Cause of Death Heart Disease		Place of Death Home	
Signature of Physician J. M. Smith		Signature of Registrar J. M. Smith	
Date of Report Dec. 16, 1950		Report Made by J. M. Smith	

RECEIVED

RECEIVED
 DIVISION OF VITAL RECORDS
 BALTIMORE, MD.
 DECEMBER 16, 1950